Advisory Council
Subcommittee Meeting
Framework for Payment

The meeting was opened by Dr Carr at 2:30 on Wednesday, September 28, 2011. The agenda was set as follows:

Introduction/Roll Call

1. Appointment of a scribe
2. Discussion of goals for PCMH in MT
    a. Short term (define timeline)
    b. Long term (" ")
3. Implications for
    a. Providers
    b. Payers
2. Discussion on best way to achieve goals
3. Steps to creating a framework for payment based on the above discussion
4. Homework

Dr Shepard agreed to be scribe for this meeting. The following were in attendance: Doug Carr, MD, Paul Cook, MD, Jonathan Griffin, MD, Jay Larson, MD, Kirsten Mailloux, Bob Marsalli, Fred Olson, MD, Tom Roberts, MD, Bob Shepard, MD, Jerry Speer, MD, Nancy Wikle.

A brief discussion of the goals of the working group covered the following topics:

1) Transformation of care as a central goal.
    1. Encouragement to Patient to seek care at lowest cost, most comprehensive and least fragmented level.
    2. Appropriate venues for care.
2) Broad Net reaching a large number of patients and encompassing care/case management
3) Sophisticated Model vs. Simple Model vs. Wish list
    1. Some initial agreement that piloting with a simple model in phase I with potential sophistication in later phase(s)

Fred Olson was asked to describe the details of early concept "medical home" programs that BCBS has made. They had consulted with plans in North and South Dakota, Nebraska. These plans use a multifaceted payment approach encompassing the following:

1) Ensure payment to offset provider expenses of PCMH development and operations
    1. certification
    2. care coordination
    3. data capture, transmission, and technology components

2) Ensure that ROI is generated (for payers to reimburse providers)
    1. improve care & coordination in chronic disease
    2. reduce utilization at higher cost venues
    3. prevention

3) Reimbursement would take the form of the following payments, in addition to FFS:
    1. pay for participation
    2. pay for quality and preventive care reporting &/or outcomes
    3. care/case management for patients with certain chronic conditions

4) Incentives for quality
    1. broad patient population preventive care, immunizations
    2. chronic disease, DM CAD, CHF, etc.

A question was asked about payment tiering. Tiering could occur by patient, by physician, or by physician group. None of the plans consulted used tiering by NCQA certification.

Physicians were paid by payer member, not paid on total cost of care.

Kirsten Mailloux

Agreed with the general framework.
Fee for service
Plus PCMH participation, quality bonuses and Case Management fee for some Dx's

They have obtained employer participation

Question about payment on a PMPM basis. BCBS indicated they preferred an annual payment. EMBS was looking at quarterly payments.

Other topics:

1) The technology platform. Comment that both platforms under consideration (MD Datacor & Doc Site) allow for the provider to see all of their patients and the plan to see all of the plans patients.
2) Likely first participants will be larger organizations, but any willing practice could participate. Though the payers may allow for non-NCQA recognized providers to participate in the first year, recognition needs to occur by **January 2013**.
3) Medical home was set up for primary care only

Next steps:

A written framework/ model that will allow for discussion at next meeting.

Next meeting October 12.